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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CAROL LU LOUIE** 4941 Gentian Court San Jose, CA 95111, **Registered Nurse License No. RN 444539** Respondent.	Case No. 2011-170 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1989, the Board of Registered Nursing issued License Number RN 444539 to Carol Lu Louie (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2011, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board),

Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states in pertinent part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . .

7. Section 2762 of the Code states in pertinent part that:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter, it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in division 10 (commencing with Section

11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

REGULATORY PROVISIONS

9. California Code of Regulations, Title 16, Section 1442, states that as used in Section 2761 of the Code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

10. California Code of Regulations, Title 16, Section 1443, states that, as used in Section 2761 of the Code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

11. California Code of Regulations, Title 16, Section 1443.5 states that a registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

(1) Formulates a nursing diagnosis through observation of the client's physical condition

and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

DRUGS

Hydromorphone Hydrochloride, also known by the brand name **Dilaudid**, is a semi-synthetic opioid derivative subject to control as a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug within the meaning of Code section 4022. Hydromorphone hydrochoride is a strong analgesic used in the relief of moderate to severe pain.

Fentanyl and Fentanyl Citrate are Schedule II controlled substances as designated by Health and Safety Code section 11055, subdivision (c)(8), and dangerous drugs within the meaning of Code section 4022. Fentanyl and Fentanyl Citrate are strong analgesics, pharmacodynamically similar to meperidine and morphine. They are used pre-operatively, during

surgery and in the immediate post-operative period, as well as for the management of breakthrough cancer pain.

Lorazepam is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug within the meaning of Code section 4022. Lorazepam, also known by the brand name **Ativan**, is a benzodiazepine, used for the management of anxiety disorders, seizure conditions and for purposes of pre-operative sedation and anxiety relief.

Benadryl Injection, the brand name for "**diphenhydramine hydrochloride**" injection is an antihistamine drug and a dangerous drug within the meaning of Code section 4022 in that it is only available by prescription.

Versed, the brand for **midazolam,** a Schedule II controlled substance as designated by Health and Safety Code section 11057(d)(21) and a dangerous drug as designated by Business and Professions Code section 4022. It is used to induce sleepiness or drowsiness and to relieve anxiety before surgery or other procedures.

Hypodermic Needle is a dangerous device within the meaning of Code section 4022 and cannot be dispensed without a prescription.

SANTA CLARA VALLEY MEDICAL CENTER

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Illegal Possession and/or Use of Controlled Substances)

12. Respondent is subject to disciplinary action under Code section 2761(a), unprofessional conduct, as defined in Code sections 2762(a) and 2762(b), in that while employed as a per diem Clincal Nurse at Santa Clara Valley Medical Center (SCVMC) in California, Respondent illegally possessed and/or used controlled substances in a manner dangerous or injurious to herself to the extent that such use impaired her ability to conduct with safety to the public the practice authorized by her license. The circumstances are as follows:

a. On or about January 16, 2009, Respondent was observed collapsed and unconscious in the Ladies bathroom located near the main entrance adjacent to the emergency room at Santa Clara Valley Medical Center. Respondent was located between the toilet and the stall wall with a

"butterfly" needle in her hand that had tubing connected to a syringe. Medical staff called to the scene observed vials of medication in Respondent's open purse that was located near Respondent. Hospital staff observed Respondent taking the medications from her purse and flushing them down the toilet. Respondent's pupils were observed to be pinpoint, her breathing shallow with a slow and weak pulse. Respondent stated to staff that she was tired and had just left her shift. Respondent admitted to hospital staff that she had taken narcotics from the intensive care unit that she just left after completing her shift.

b. Respondent later told the physician examining her that she had injected Benadryl in the bathroom after her shift and had fallen asleep. Respondent has not provided a prescription for a Benadryl injection.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

13. Respondent is subject to disciplinary action under Code section 2761(a)(1), unprofessional conduct, incompetence, as defined in CCR sections 1443 and 1443.5 in that while employed as a Registered Nurse at Santa Clara Valley Medical Center, California, on January 16, 2006, just prior to the incident described in Paragraph 12 above, Respondent repeatedly was incompetent as follows:

a. Respondent failed to chart vital signs on tow of her patients, failed to timely implement a discontinue order for Versed and failed to perform any required charting near the end of her shift.

GOOD SAMARITAN HOSPITAL

14. While employed at the Good Samaritan Hospital in San Jose, Respondent was responsible for the following patients:

Patient 1:

a. On May 6, 2007, Patient 1's physician ordered Fentanyl 50 mcg (1 ml. per dose) to be administered intravenously every 30 minutes as needed for moderate pain. On May 10, 2007,

according to Good Samaritan Hospital's medication dispensing system (AcuDose[1]), Respondent removed one Fentanyl 100 mcg/2ml syringe at 2036 hours for Patient 1. Respondent documented in the patient's medication administration record (MAR) that she administered 50 mcg Fentanyl to the patient at 2032 hours and 50 mcg Fentanyl at 2112 hours (1 hour 16 minutes since dispensation). Respondent failed to promptly administer Fentanyl following the removal of this drug.

b. On May 10, 2007, at 2213 hours, Respondent removed one Fentanyl 100 mcg/2ml syringe. Respondent documented in the patient's MAR that she administered 50 mcg Fentanyl at 2210 hours and 50 mcg Fentanyl at 2306 hours (1 hour and 13 minutes since dispensation). Respondent failed to promptly administer Fentanyl following the removal of this drug.

c. On May 11, 2007, at 0005 hours, Respondent removed one Fentanyl 100 mcg/2ml syringe for Patient 1. Respondent documented in the patient's MAR that she administered 50 mcg Fentanyl at 0002 hours and 50 mcg Fentanyl at 0114 hours (1 hour 9 minutes from dispensation). Respondent failed to promptly administer Fentanyl following the removal of this drug.

d. On May 11, 2007, at 0418 hours, Respondent removed one Fentanyl 100 mcg/2ml syringe for Patient 1. Respondent documented that she administered 50 mcg Fentanyl at 0430 hours and 50 mcg Fentanyl at 0713 hours (2 hours 35 minutes since dispensation). Respondent failed to promptly administer Fentanyl following the removal of this drug.

e. On May 11, 2007, Patient 1's physician ordered Fentanyl 75 mcg (1.5 ml. per dose) to be administered intravenously every 30 minutes as needed for severe pain. On May 11, 2007, at 2041 hours, Respondent removed 100mcg/2ml syringe for Patient 1. There is no record in the MAR that the Fentanyl was given to Patient 1. Respondent failed to document Patient 1's pain level. At 2045, Respondent wasted Fentanyl 25 mcg with a witness. Respondent failed to account for 75 mcg of Fentanyl.

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[1] AcuDose is a hospital computerized medication storage system.

f. On May 12, 2007, at 0303 hours, Respondent removed one Fentanyl 100 mcg/2ml syringe for Patient 1. Respondent documented that she administered 75 mcg Fentanyl at 0311 hours and at 0557 wasted 25 mcg with a witness (2 hours 54 minutes since dispensation). Respondent failed to promptly waste Fentanyl 25 mcg following the removal and administration of this drug.

g. On May 12, 2007, at 0552 hours, Respondent removed one Fentanyl 100 mcg/2ml syringe for Patient 1. Respondent documented that she administered 75 mcg Fentanyl at 0552 hours and at 0752 wasted 25 mcg with a witness (2 hours since dispensation). Respondent failed to promptly waste Fentanyl 25 mcg following the removal and administration of this drug.

Patient 2:

h. On May 17, 2006, Patient 2's physician ordered Fentanyl, via patient-controlled analgesia (PCA), 50 mcg/ml to be administered intravenously as needed. On May 20, 2007, Patient 2 was transferred from 3Med to Med-Surgery Intensive Care Unit (MSIC) and arrived at 1830 hours with an already infusing Fentanyl PCA. Patient 2 was transferred back to 3 Med at 2215 hours.

On May 20, 2007, Respondent accessed the AcuDose system at 2116 hours for Patient 2 and removed one dose of Fentanyl PCA 50 mcg/ml. The medication count was listed as beginning at 1,931 and ending at 1,930. There is no record indicating that Respondent or any other nurse administered the medication to Patient 2 that was removed by Respondent at 2116 hours. Moreover, since Patient 2 arrived at Respondent's nursing unit with an already infusing PCA of Fentanyl, which started at 1442 with a total of 2500 mcg and a 250 mcg/hr limit, Patient 2 had 10 hours of Fentanyl in place beginning at 1442. At the time of transfer to MSIC, Patient 2 was only 4 hours into the maximum possibly allowed and at the time Respondent accessed the AcuDose, had 6.5 hours possibly allowed. There would have been no reason to dispense on behalf of this patient at the time Respondent accessed the AcuDose. Respondent failed to account for one dose of Fentanyl 50mcg/ml.

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THIRD CAUSE FOR DISCIPLINE

(Illegally Obtain or Possess Controlled Substances)

15. Respondent is subject to disciplinary action under Code section 2761(a), unprofessional conduct, as defined in Code Section 2762(a), in that while employed as a Registered Nurse at Good Samaritan Hospital in San Jose, California, Respondent illegally obtained and/or possessed controlled substances as follows:

a. Respondent failed to account for 75 mcg of Fentanyl as described more fully in Paragraph 14.e. above.

b. Respondent failed to account for one dose of Fentanyl 50mcg/ml as described more fully in Paragraph 14.h. above.

FOURTH CAUSE FOR DISCIPLINE

(Incompetence)

16. Respondent is subject to disciplinary action under Code section 2761(a)(1), unprofessional conduct, incompetence, as defined in CCR sections 1443 and 1443.5 as follows:

a. Respondent failed to promptly administer Fentanyl following the removal of this drug as more fully described in Paragraph 14.a., 14.b., 14.c. and 14.d. above.

b. Respondent failed to promptly waste Fentanyl following the removal and administration of this drug as more fully described in Paragraph 14.f. and 14.g.

FIFTH CAUSE FOR DISCIPLINE

(False and/or Grossly Incorrect, Grossly Inconsistent Records)

17. Respondent is subject to disciplinary action under Code section 2762(e), in that while employed as a Registered Nurse at Good Samaritan Hospital in San Jose, California, Respondent repeatedly made false and/or grossly incorrect, grossly inconsistent, entries in the hospital's records resulting in drug and charting discrepancies for patients as set forth in Paragraphs 14.a.-g. above.

COMMUNITY HOSPITAL OF LOS GATOS

18. While employed at the Community Hospital of Los Gatos (CHLG) as a clinical nurse in the Intensive Care Unit - Critical Care Unit (ICU-CCU), Respondent was responsible for the

following patients:

Patient 1:

a. On February 2, 2008, at 2100 hours, Patient 1's physician ordered Fentanyl infusion, 50 mcg, then 50 mcg per hour, titrate to maintain a respiratory rate between 12 and 32 (respiration per minute). This order was written and signed by the physician.

According to CHLG's medication dispensing system (Pyxis[2]), on February 2, 2008, Respondent removed Fentanyl 2500 mcg/50 ml syringe at 2029 hours for use in Patient 1's infusion pump. At CHLG, the infusion has a separate Medication Administration Record (MAR) entitled Fluid Therapy MAR (FTMAR). Patient 1's FTMAR shows the physician's order as stated above. On the FTMAR, Respondent documented the time of administration on February 2, 2008 as "25" and wrote "200 mcg" and her initials next to that entry. This is an incomplete entry.

Also on the FTMAR, Respondent documented that she increased Patient 1's Fentanyl infusion to 300 mcg at 2400 hours on February 2, 2008. CHLG also uses a form called a narcotic infusion record. This form shows that Respondent began the IV infusion on February 2, 2008, at 2130 with a rate of 50 mcg and increased the dose to 300 mcg at 2400. On February 3, 2008, the infusion rate was progressively increased until Patient 1 reached a respiration rate of 32 at 0915. This form, the narcotic infusion record, shows the accurate accounting of the progression of Fentanyl, but Patient 1's FTMAR does not. In addition, there were no pain scores entered on the narcotic infusion record.

b. Patient 1's non-infusion MAR has a handwritten entry for Fentanyl 50 mcg IV X1 on February 2, 2008. There is no corresponding Physician's Order for that entry. Respondent documented that she administered the medication at 1950 hours. According to Pyxis, Respondent removed Fentanyl 100 mcg at 1956 hours for Patient 1. Respondent failed to account for 50 mcg of Fentanyl.

c. Patient 1's non-infusion MAR has an entry for Fentanyl bolus 50-100 mcg as needed for breakthrough pain on February 2, 2008. Respondent documented that she gave

[2] Pyxis is a hospital computerized medication storage system.

Fentanyl 50 mcg IV at 2130 using this MAR notation. There is no Physician's Order corresponding to this entry.

d. On February 3, 2008 at 0012 hours, Respondent removed Fentanyl 100 mcg. Respondent used the MAR entry for Fentanyl bolus 50-100 mcg as needed for breakthrough pain to give Fentanyl 100 mcg IV. There is no Physician's Order corresponding to this entry.

e. On February 3, 2008 at 0518 hours, Pyxis shows that Respondent removed Fentanyl 100 mcg for Patient 1. There is no Physician's Order corresponding to this entry and there is no documentation in the MAR to show that the patient received the medication. The patient's Critical Care Flow Sheet has an entry for Fentanyl 100 mcg at 0515.

f. Patient 1 had a Physician's Order for Ativan 1 mg every hour as needed for agitation that was written on January 20, 2008. On February 3, 2008, Respondent dispensed Ativan 2 mg at 0612 hours. Respondent documented on the patient's MAR that 1 mg of Fentanyl was given at "06" hours. This time entry was incomplete.

g. Patient 1's non-infusion MAR dated February 3, 2008, has a notation "give 400 mcg of Fentanyl IVP NOW." There is no Physician's Order corresponding to this entry. Respondent documented on Patient 1's non-infusion MAR that that she administered 300 mcg of Fentanyl at 1050 hours. The notation appears in the column titled "0001-0700" referring to a time block. Respondent's entry of 1050 does not fall into this time block. There is no corresponding Pyxis report entry that shows that Respondent withdrew Fentanyl 300 mcg or 400 mcg for Patient 1 on February 3, 2008. This entry is erroneous.

h. Patient 1's critical care flow sheet indicates that Patient 1 was assigned to Respondent on February 2, 2008. Patient 1's critical care flow sheet is missing entries, assessments, notations and is a complete failure to document the assessment data critical to accurate care and financial records of the patient as well as communications between patient heath care team members.

Patient 2:

i. Patient 2 had a Physician's Order for Hydromorphone (Dilaudid) 1 mg every 30 minutes as needed for breakthrough pain. According to Pyxis, Respondent removed Dilaudid 2

mg/1 ml syringe on February 6, 2008, at 0318 hours. There is no entry in the patient's MAR to show that Dilaudid was administered to the patient. There is only a notation on the patient's Critical Care Sheet that states Dilaudid 1 mg at 0345 hours. Respondent failed to account for the administration or disposition of 2 mg of Dilaudid.

j. On February 6, 2008, at 0429 hours, the Pyxis report indicates that Respondent removed Dilaudid 2 mg/1 ml syringe for Patient 2. The MAR shows that Respondent administered 1 mg of Dilaudid at 0430 and wasted 1mg Dilaudid at 0644. Respondent failed to promptly waste 1mg Dilaudid following the removal and administration of this drug.

k. On February 6, 2008, at 0516 hours, the Pyxis report indicates that Respondent removed Dilaudid 2mg/1 ml syringe for Patient 2. The MAR shows that Respondent administered 1 mg of Dilaudid at 0516 and wasted 1mg Dilaudid at 0644. Respondent failed to promptly waste 1mg Dilaudid following the removal and administration of this drug.

l. On February 7, 2008, at 0357, the Pyxis report indicates that Respondent removed Dilaudid 2mg/1 ml syringe for Patient 2. The MAR shows that Respondent administered 1 mg of Dilaudid at 0540 and wasted 1mg Dilaudid at 0357. This is either an error in charting time or an excessive time interval from dispensing to administering (one hour, 40 minutes).

Patient 3:

m. Patient 3 had a Physician's Order dated March 10, 2008, for Dilaudid 1 mg IV every hour as needed for moderate to severe pain. According to Pyxis, on March 11, 2008, Respondent removed Dilaudid 2 mg/1 ml syringe at 0501 hours. Patient 3's MAR shows that Dilaudid 1 mg was given to the patient at "05." There is no further documentation to show if the remaining 1 ml of medication was administered to the patient or wasted. Respondent failed to account for the Dilaudid 1 mg/1 ml.

Patient 4:

n. Patient 4 had a Physician's Order dated May 7, 2008, for Morphine Sulfate 2 mg IV every 30 minutes as needed for break through pain. The Pyxis report indicates that that Respondent removed 2 mg/ 1 ml of Morphine Sulfate on May 7, 2008, at 2026 hours. There is no

documentation on Patient 4's MAR to show whether Respondent administered the medication to the patient or wasted it. Patient 4's Flow Sheet shows Morphine Sulfarte 2 mg was administered to Patient 4 at 2020 hours. There is a discrepancy between Patient 4's Flow Sheet and the MAR.

o. On May 7, 2008, at 2129, the Pyxis report indicates that Respondent removed 2 mg/ 1 ml of Morphine Sulfate for Patient 4. Respondent failed to account for this medication as there is no documentation on Patient 4's MAR to show whether Respondent administered the medication to the patient or wasted it. Patient 4's Flow Sheet shows Morphine Sulfarte 2 mg was administered to Patient 4 at 2120 hours. There is a discrepancy between Patient 4's Flow Sheet and the MAR.

p. According to Pyxis, at 2026 hours, Respondent removed 2 mg/1 ml of Morphine Sulfate for Patient 4. Respondent failed to account for this medication as there is no further documentation to show that Respondent administered the medication to the patient or to account for its disposition.

q. Patient 4 also had a Physician's Order dated May 7, 2008, for Fentanyl 25 mcg every 30 minutes as needed for pain not controlled by an epidural. According to Pyxis, on May 7, 2008, Respondent removed Fentanyl 100 mcg/2 ml at 2300 and administered 25 mcg Fentanyl at "23" and wasted 75 mcg at 2300. Respondent made two distinct entries on MAR, initialing both entries, that she gave Fentanyl at "23" and at "00." These are incomplete and/or inaccurate time entries and there is no withdrawal of Fentanyl to correspond with "00."

r. On May 8, 2008, Respondent removed Fentanyl 100 mcg/2 ml at 0103 hours and the same amount again at 0245 hours. Respondent failed to account for these medications as there is no MAR documentation that the medications were administered. Pyxis does show that 75 mcg Fentanyl was wasted at 0103 hours and that 75 mcg Fentanyl was wasted at 0245 hours.

Patient 6:

s. Patient 6 had a Physician's Order dated July 8, 2008, for Dilaudid 0.25 mg IV every 15 minutes as needed for breakthrough pain. The Pyxis report for July 9, 2008, shows that Respondent removed Dilaudid 2 mg/1 ml at 0210 hours with 1 mg wasted also at 0210 hours.

Respondent failed to account for 1 mg Dilaudid as there is no further documentation anywhere to show that Respondent administered the remaining 1 mg of Dilaudid.

t. On July 9, 2008, Pyxis report indicates that Respondent removed 2 mg/1 ml of Dilaudid at 0416 hours with 1 mg wasted also at 0416 hours. Respondent failed to account for 1 mg Dilaudid as there is no further documentation anywhere to show that Respondent administered the remaining 1 mg of Dilaudid.

u. On July 9, 2008, Pyxis report indicates that Respondent removed 2 mg/1 ml of Dilaudid at 0629 hours with 1.75 mg wasted also at 0629 hours. Respondent failed to account for .25 mg Dilaudid as there is no further documentation anywhere to show that Respondent administered the remaining .25 mg of Dilaudid.

SIXTH CAUSE FOR DISCIPLINE

(Illegally Obtain or Possess Controlled Substances)

19. Respondent is subject to disciplinary action under Code section 2761(a), unprofessional conduct, as defined in Code Section 2762(a), in that while employed as a Registered Nurse at Community Hospital of Los Gatos, California, Respondent illegally obtained and/or possessed controlled substances as follows:

a. Respondent failed to account for 50 mcg of Fentanyl as described more fully in Paragraph 18.b. above.

b. Respondent failed to account for 1 mg Dilaudid as described more fully in Paragraph 18.m. above.

c. Respondent failed to account for 2 mg Morphine Sulfate as described more fully in Paragraph 18.n. above.

d. Respondent failed to account for 2 mg Morphine Sulfate as described more fully in Paragraph 18.o. above.

e. Respondent failed to account for 2 mg Morphine Sulfate as described more fully in Paragraph 18.p. above.

f. Respondent failed to account for 200 mcg of Fentanyl as described more fully in Paragraph 18.r. above.

g. Respondent failed to account for 1 mg Dilaudid as described more fully in Paragraph 18.s. above.

h. Respondent failed to account for 1 mg Dilaudid as described more fully in Paragraph 18.t. above.

i. Respondent failed to account for .25 mg Dilaudid as described more fully in Paragraph 18.u. above.

SEVENTH CAUSE FOR DISCIPLINE

(Incompetence and/or Gross Negligence)

20. Respondent is subject to disciplinary action under Code section 2761(a)(1), unprofessional conduct, gross negligence, as defined in CCR section 1442, and/or incompetence, as defined in CCR sections 1443 and 1443.5, in that while employed as a Registered Nurse at Community Hospital of Los Gatos, Respondent repeatedly made false and/or grossly incorrect, grossly inconsistent, entries in the hospital's medication dispensing records (Pyxis) resulting in numerous drug discrepancies for patients as noted in a selection of specific instances set forth in paragraph 18.a.-u., above.

EIGHTH CAUSE FOR DISCIPLINE

(False and/or Grossly Incorrect, Grossly Inconsistent Records)

21. Respondent is subject to disciplinary action under Code section 2762(e), in that while employed as a Registered Nurse at Community Hospital of Los Gatos, California, Respondent repeatedly made false and/or grossly incorrect, grossly inconsistent, entries in the hospital's records resulting in drug and charting discrepancies for patients as set forth in Paragraphs 18.a.-u. above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number RN 444539, issued to Carol Lu Louie

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2. Ordering Carol Lu Louie to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 8/31/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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